

| | | | | | | | |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| K0000 | <p>A Life Safety Code Recertification, State Licensure, and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/25/12</p> <p>Facility Number: 000541 Provider Number: 155475 AIM Number: N/A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Towne House Retirement Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a</p> | | K0000 | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|--|---|--|--|--|----------------------------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | | |
| | <p>walkout lower level below the southeast wing was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms. The facility has a capacity of 101 and had a census of 62 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered.</p> <p>The facility has a detached barn providing facility services including storage of mowers, maintenance equipment and two buses that was not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/30/12.</p> <p>The facility was found not in</p> | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012

FORM APPROVED

OMB NO. 0938-0391

| | | | | | | | |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | compliance with the aforementioned regulatory requirements as evidenced by the following: | | | | | | |

| | | | | | | | |
|--|---|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| K0021 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 rolling fire doors in a smoke/fire barrier wall would close upon activation of the fire alarm. This deficient practice could affect any resident in the main dining room and any kitchen staff in the event of an emergency.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Supervisor on 07/25/12 at 4:10 p.m., the rolling fire door at the window between the kitchen and the main dining room did not close upon activation of the fire alarm. The rolling fire door is in a smoke/fire</p> | K0021 | K0021 The Towne House does not agree with this finding. This rolling door has been in service since 1984 when the building was built. As noted in the finding, the door is on a fusible link. At the time of the survey, the surveyor indicated that she was not sure about the requirement for this door. Therefore, there was an uncertainty about the requirement even by the state. Last year, the surveyor issued another finding with this door, indicating that the door had not been inspected on a timely basis, but did not indicate that door needed to be on the alarm system. The Towne House will replace the door and connect the new door to the fire alarm system. The cost for the new door is \$3667. A new door has been ordered on August 9, 2012. However, due to the unique size of the door, it will take | 10/19/2012 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|--|--|--|--|--|---|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | barrier wall. Based on an interview with the Maintenance Supervisor at the time of observation, the rolling fire door is on a fusible link. 3.1-19(b) | | | | approximately ten weeks to be delivered and installed. We anticipate that this should be completed by October 19, 2012. The Environmental Services Director will be responsible for monitoring. | | |

| | | | | | | | |
|--|---|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| K0044 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 1 of 4 main floor smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/25/12 at 2:35 p.m., when entering the residential building from the health care building, the right side two hour fire door failed to latch into the frame. Based on</p> | | K0044 | <p>K0044 The Towne House does not agree with this finding. The door that is noted with the automatic door opener has been in use since the 1990's. There have been many surveys during that time when this door was found to be in compliance. The Towne House will replace the latching system on this door so that latch will be connected to automatic door opener. The cost for this upgrade is \$4173. The new latching system was ordered on August 2, 2012 and will take approximately eight weeks to be delivered and installed. We anticipate that should be completed by September 27, 2012. The Environmental Services Director will be responsible for monitoring.</p> | | 09/27/2012 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|--|--|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | <p>an interview with the Maintenance Supervisor at the time of observation, the latching mechanism had been removed to allow the door to swing open when the handicapped access button was pressed.</p> <p>3.1-19(b)</p> | | | | | | |

| | | | | | | | |
|--|--|--|---------------------|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| K0067 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure an undetermined number of dampers throughout the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> | | K0067 | <p>K067 The Towne House does not agree with this finding. Dampers were inspected on a timely basis. However, at the time of the survey, The Director of Environmental Services was on vacation. The documents requested were not able to be found by staff working at that time. When the Director of Environmental Services returned he was able to locate the documents which indicated that the dampers had been inspected in August 2011 and were in working order. Those documents are available at this time. The Environmental Services Director will be responsible for monitoring. Completion Date: August 10, 2012</p> | | 08/10/2012 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012
FORM APPROVED
OMB NO. 0938-0391

| | | | | | | | |
|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/25/2012 | |
| NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| | <p>Based on observation with the Maintenance Supervisor on 07/25/12 at 3:20 p.m., there were fire dampers in the AC supply vents of the laundry room. Based on an interview with the Maintenance Supervisor at the time of observations, he stated there were numerous dampers throughout the facility. According to the Maintenance Supervisor the dampers were recently inspected but he was unable to provide the documentation to show the dampers were inspected and in proper working order.</p> <p>3.1-19(b)</p> | | | | | | |